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ABSTRACT

The manual is designed to assist primarily public school personnel who are involved in the identification and delivery of services to young handicapped children (birth to 5 years old) and their families. An introductory chapter explains the manual's purpose and background. Chapter 2 focuses on child find activities with sections on awareness, location/identification, screening, referral/case study evaluation, and multidisciplinary conference and determination of eligibility for placement. Chapter 3 addresses the five critical components of an exemplary early childhood program for the handicapped: setting, facilities and equipment, curriculum and instructional strategies, parent involvement, and personnel. A fourth chapter addresses the training needs of the teaching staff, and views personnel preparation as an ongoing process of professional development rather than a series of short term training activities which culminate with the award of an academic degree. A final chapter discusses the provision of educational and related services to handicapped children birth to 3 years old. Chapters 2 through 5 contain an evaluation section and a list of recommendations. Included in the appendixes is a sample evaluation design table which lists evaluation questions, procedures, and directions. (SBH)

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EARLY CHILDHOOD EDUCATION FOR THE HANDICAPPED: RECOMMENDED PROCEDURES AND PRACTICES

Illinois State Board of Education
Department of Specialized Educational Services
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Springfield, Illinois 62777
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State Superintendent of Education

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TABLE OF CONTENTS

Foreword i

Chapter One
The Purpose and Process of Developing this Manual 1

Chapter Two
Child Find 3

Chapter Three
Critical Components of an Exemplary Early Childhood Program for the Handicapped 7

Chapter Four
Personnel Preparation and Staff Development 17

Chapter Five
Birth-to-Three Services 27

Appendices
A. Evaluation of Early Childhood Education Programs 34
B. Steering Committee and Task Force Members 45

FOREWORD

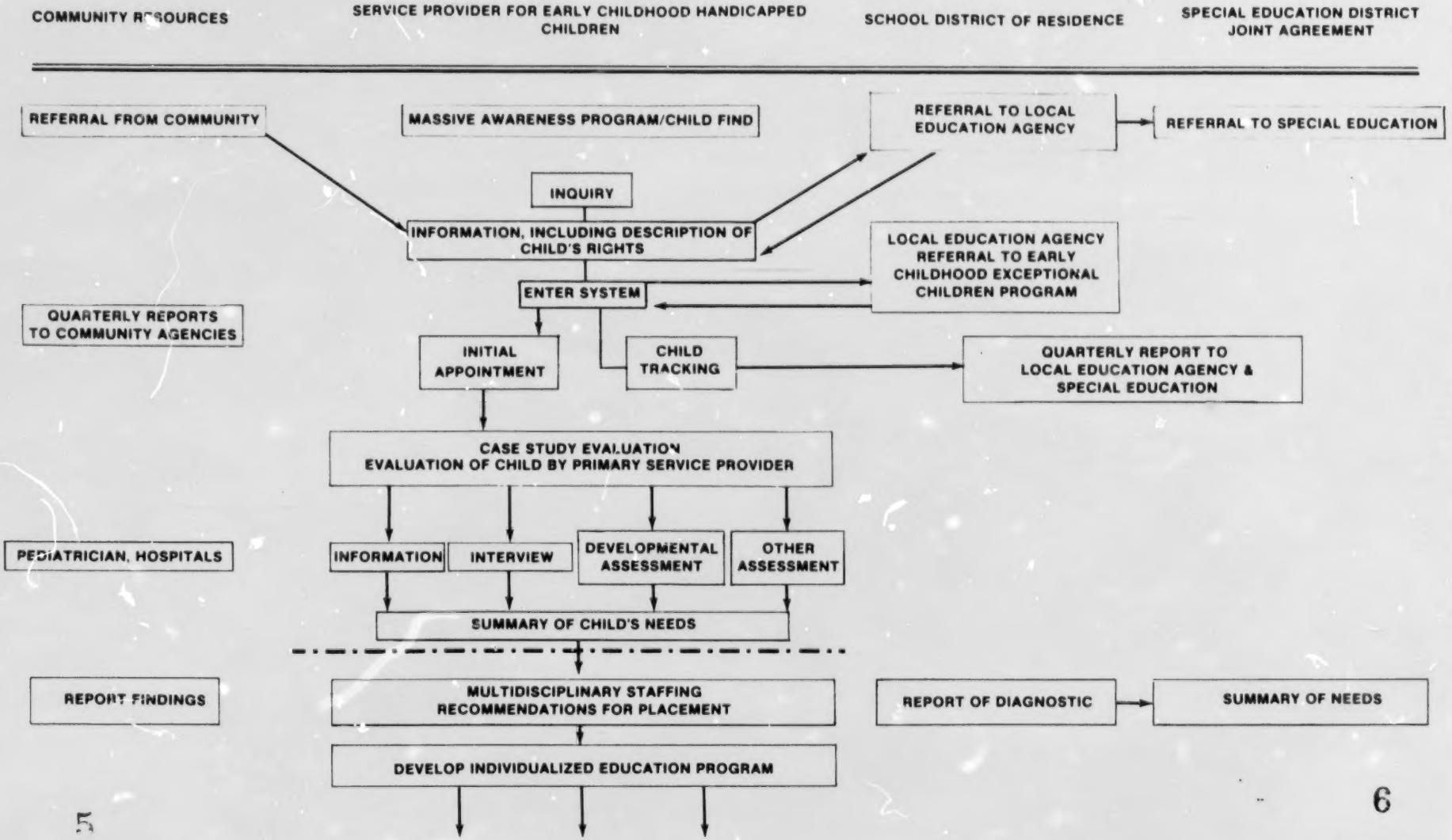
The Illinois State Board of Education is pleased to make available this edition of Early Childhood Education for the Handicapped: Recommended Procedures and Practices. The purpose of the manual is to offer assistance to personnel involved in the delivery of services to young handicapped children and their families.

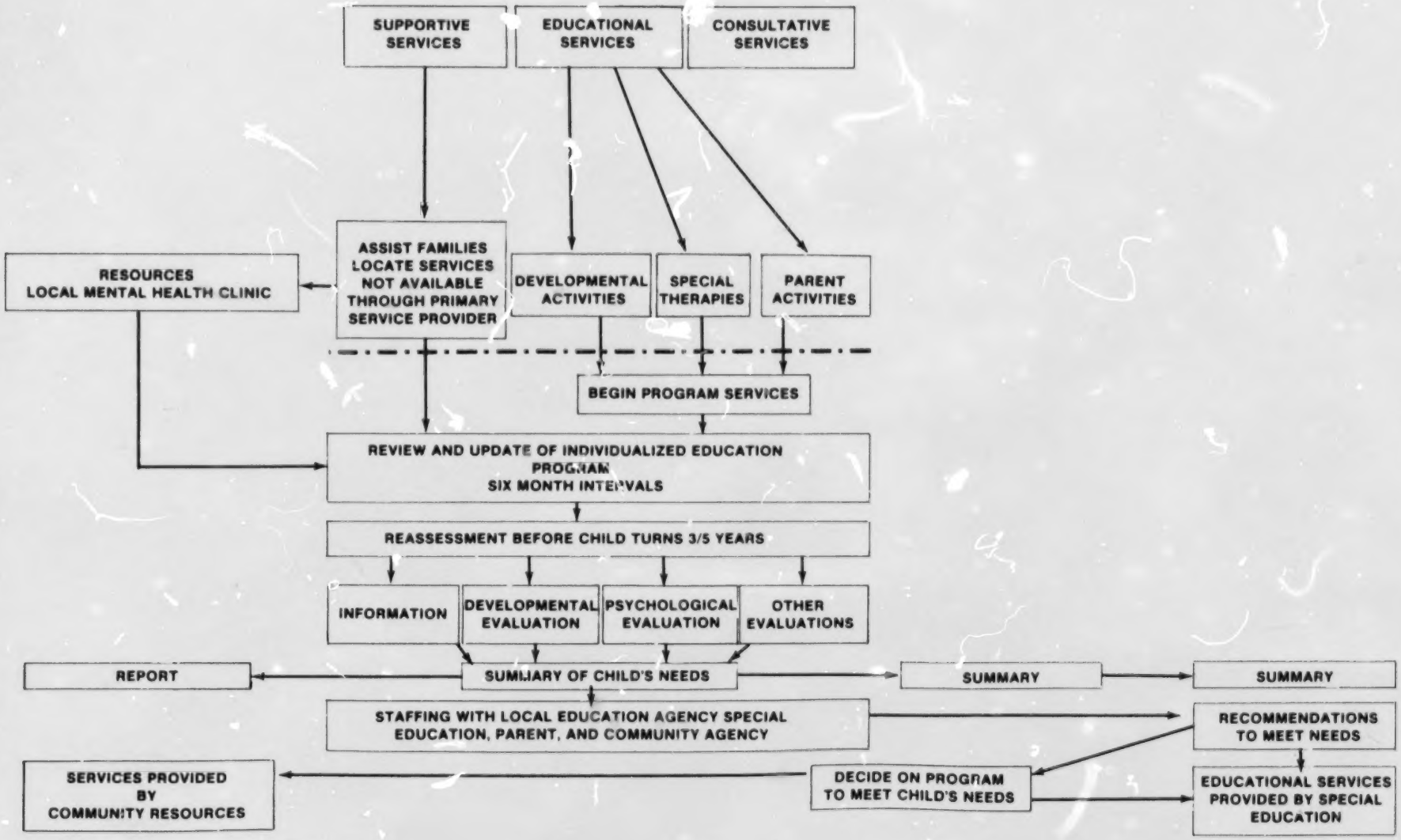
The manual was developed by a task force and steering committee composed of Illinois representatives of public and private schools, universities and other agencies, as well as parents of handicapped preschoolers. These committee members contributed generously of their enthusiasm, expertise, and commitment to better serving young handicapped children. A list of task force and steering committee members appears in the appendices of this manual. These individuals should be considered excellent resources for the information contained herein. Appreciation is extended to them, as well as to the consultants (named in Chapter One), who assisted in the brainstorming of the manual. Additionally, appreciation is extended to Julie Carter of the Illinois State Board of Education, Department of Specialized Educational Services, who coordinated all phases of the development of this manual, and to Linda Avery, also in the Department of Specialized Educational Services, for developing Appendix A of this manual.

It is anticipated that this manual will serve as a valuable resource to the field of early childhood education for the handicapped, as well as for other related fields of education. It is hoped that it will serve as a catalyst for development and improvement of high-quality programs to this very special group of children.

Joseph M. Cronin
State Superintendent of Education

PROCESS MODEL FOR DELIVERY OF SERVICES TO EARLY CHILDHOOD HANDICAPPED CHILDREN




SUPPORTIVE SERVICES
EDUCATIONAL SERVICES
CONSULTATIVE SERVICES
ASSIST FAMILIES LOCATE SERVICES NOT AVAILABLE THROUGH PRIMARY SERVICE PROVIDER
RESOURCES LOCAL MENTAL HEALTH CLINIC
DEVELOPMENTAL ACTIVITIES
SPECIAL THERAPIES
PARENT ACTIVITIES
BEGIN PROGRAM SERVICES
REVIEW AND UPDATE OF INDIVIDUALIZED EDUCATION PROGRAM
SIX MONTH INTERVALS
REASSESSMENT BEFORE CHILD TURNS 3/5 YEARS
INFORMATION
DEVELOPMENTAL EVALUATION
PSYCHOLOGICAL EVALUATION
OTHER EVALUATIONS
REPORT
SUMMARY OF CHILD'S NEEDS
SUMMARY
SUMMARY
STAFFING WITH LOCAL EDUCATION AGENCY SPECIAL EDUCATION, PARENT, AND COMMUNITY AGENCY
RECOMMENDATIONS TO MEET NEEDS
SERVICES PROVIDED BY COMMUNITY RESOURCES
DECIDE ON PROGRAM TO MEET CHILD'S NEEDS
EDUCATIONAL SERVICES PROVIDED BY SPECIAL EDUCATION

Chapter One
THE PURPOSE AND PROCESS OF DEVELOPING THIS MANUAL

Purpose

The purpose of this manual is to assist those persons involved in the identification of and delivery of services to young handicapped children and their families. The primary audience is public school personnel. However, the Illinois Office of Education is well aware of the variety of service providers not affiliated with the public schools. It is therefore also the intent of this manual to be of assistance to those outside of public schools who engage in meeting the needs of birth through five year old handicapped children.

The information contained herein can serve as the basis for establishing or improving an early childhood special education program. The manual deals with "program" in terms of child find, critical components of an exemplary early childhood program for the handicapped, and personnel preparation and staff development. While public schools are currently mandated to provide services beginning at three years of age, there is a growing interest in meeting the needs of handicapped children from birth. As a result of this interest, this manual can generally be applied to services for birth through five year olds, and also specifically addresses services for birth to three year olds.

The intent of the manual is to offer suggestions and alternatives to service providers which are applicable in most cases regardless of the model used or the philosophical persuasion of professionals and parents. It is not the intent of the manual to reiterate either federal or state rules and regulations. The reader is strongly encouraged to use this manual in conjunction with The School Code of Illinois, the Illinois Rules and Regulations to Govern the Administration and Operation of Special Education, the Federal Regulations for Public Law 94-142, and any additional regulations which affect early childhood programs. Additionally, the recommended procedures and practices contained herein will not be used as a basis for evaluating or monitoring existing programs.

Table I is included here to set the tone for the manual. It is designed to emphasize the flow of services and the importance of cooperative service efforts regardless of which agency/program initially assumes responsibility for any given child.

Background

During the 1977-78 school year, the Illinois Office of Education recognized a need to provide additional guidance to districts involved in providing early childhood special education services. The Professional Development Centers, funded by the Illinois Office of Education, conducted a survey of current early childhood services in the public schools. This information was compiled and served as the background material for the working groups.

In January, 1978, Dr. Diane Bricker, Dr. Merle B. Karnes, Dr. David Lillie, and Dr. Lizbeth Vincent consulted with the Illinois Office of Education, outlining critical variables of early childhood special education programs and

suggesting vehicles for service delivery. The results of their activities were shared with a seven member Steering Committee, who had been appointed by the Illinois Office of Education to spearhead the development of this manual.

In addition to appointing a Steering Committee, an Early Childhood Task Force was appointed. The two bodies represented local superintendents, special education directors, early childhood supervisors and teachers, supportive personnel, institutions of higher education, parents, and selected other agencies. The Steering Committee had the responsibility of designing the make-up of the manual and chairing working committees of Task Force members.

An orientation session took place in February, 1978, at which time the Task Force learned its role in this process and selected topics of interest. A month followed during which individuals researched their topics. A three day working retreat was held in March, at which time the manual began to take shape. The Steering Committee members compiled the vast information generated at the working retreat into the first draft of the working paper.

Dr. Eugene Edgar, University of Washington, lent his background and expertise by critiqueing, analyzing, and revising the first draft. His efforts were reviewed by the Steering Committee and subsequent changes were made resulting in Draft II of the working paper. This second draft then went to the Task Force members for their reactions and suggestions. This information was incorporated into Early Childhood Education for the Handicapped: Recommended Procedures and Practices, draft edition.

Approximately 3,500 copies of the draft were distributed, beginning in September, 1978. Suggestions and comments were solicited throughout the year, culminating with statewide public hearings in March and April, 1979. All suggestions were carefully studied and appropriate revisions to the draft were made accordingly. It is the intent and hope of the Illinois State Board of Education that this revised, final document will serve as an important resource to early childhood service providers, now and in the future.

Chapter Two

CHILD FIND
Goal: To Locate All Handicapped Children Within a Given Area

DISCUSSION

Child find is a mutually shared activity between federal, state and local agencies. Although this activity may be shared, the final responsibility rests with the local education agency (LEA). The desired outcome of all child find activities is to place all handicapped children in appropriate intervention programs. Child find, as discussed here, includes the following components: awareness, location, identification, screening, referral, case study, multidisciplinary conference, and determination of placement. Children with handicaps include those with a wide variety of characteristics (such as physical handicaps, maladjustment, specific learning disabilities, mental retardation, and speech/language impairment) covering a broad range from very mild involvement to very severe. With the preschool child it is not always possible to provide a definitive diagnosis. There are instances in which a child is at risk for developing conditions which may later interfere with his/her ability to function successfully in the normally accepted environment. Other children exhibit delays in development with no apparent explanation as to the cause of the problems.

Because of these complexities, it is important that each step of the child find process, as identified above, be followed. The combination of the components is more likely to yield an understanding of the early childhood handicapped population under consideration.

Awareness

LEAs need to attend to the problem of increasing public awareness in the following areas, including awareness of:

1. the importance of early intervention
2. availability of programs/services
3. parent/child rights under federal/state law
4. early warning signs that signify a referral

The importance of early intervention. The preschool years are generally considered the most important years for learning to occur. For handicapped children, early detection is especially important because it makes it possible to intervene with children with handicaps or potential handicaps, increases the likelihood that many children will later function without the need for special intervention, and begins the important process of including parents in the understanding and care of their children with handicaps. Each LEA should saturate its community with information regarding the importance of early identification and intervention for young handicapped children. This will result in increased community awareness, involvement and support for early childhood education programs. Simultaneously, awareness activities conducted by the state should support and enhance the LEA activities.

Availability of program services. While local programs for young handicapped children are often available, they have not been adequately advertised so that parents can take advantage of the services. Each LEA in concert with state, joint agreement, and/or regional agencies should publish a list of services available to children and parents, and ensure massive distribution of this information. Additionally, every opportunity should be taken to discuss this availability at parent organization and community service group meetings.

Parent/child rights under federal/state laws. Parents need to be made aware not only that programs are available for young handicapped children, but also that public schools in Illinois have a mandate to provide services beginning at three years of age. Each LEA, with the assistance of state, joint agreement, and/or regional education agencies should strive for this level of public awareness and simultaneously appraise parents of all the legal rights to which they and their child, beginning at three years of age, are entitled as a result of state and federal education laws.

Early warning sign detection. Each LEA should inform parents of potential warning signs that would encourage parents to seek a professional assessment. If more parents were attuned to detecting delays and asking questions of their doctors, school personnel, etc., early detection and treatment could begin as quickly as possible.

The above awareness activities, taken as a group, will do much to activate a community to support and improve early intervention programs within the schools.

Location/Identification

Before handicapped children can be referred to appropriate services they must be located and identified. Location refers to the activity of clearly isolating the exact number and location of all children in a given geographic area. This information greatly facilitates formal screening activities.

In identification, it is necessary to define the target population, increase the public's awareness of the availability of services, and encourage referrals. There are at least three ways that identification may occur. First there may be direct referral by a parent. In this case the parent approaches the school and asks for help for his/her child. Second, referrals may come from another community agency, hence the importance of close, personal contact with all local human resource agencies. Third is referral from the private sector, with physician referral being the most common.

These three types of identification procedures are dependent on three factors: 1) a local agency (LEA) to which referrals can be made (of special importance is the existence of a name and phone number which is common knowledge to all potential referral sources); 2) a general community awareness that educational programs are available for preschool handicapped; and 3) a general belief that these educational programs are important for preschool handicapped children. This latter issue is of primary importance if referrals are to be anticipated from the medical community.

Screening

Those children who are obviously handicapped will, hopefully, be referred to the school by the procedures noted under identification. However, there are many children without visible handicaps who may, nevertheless, be in need of early intervention. For these children, screening procedures are required. Screening can best be defined as a systematic process for determining which individuals from the general population are more likely than others to have a specific problem. Screening procedures must therefore be directed to a specific type of problem. Although the procedures should be quick and inexpensive, it is important that the persons conducting the screening be properly trained to do so. The purpose of screening is to identify those who may have the problem and not those who do not have the problem. Screening is not assessment. No individual is diagnosed or placed in a special program solely on the results of screening. Rather, those individuals who are identified as "at risk" (likely to have the problem) through screening efforts should be referred for further in-depth diagnostic/assessment procedures in order to determine if the problem actually exists, and to what degree.

Referral/Case Study Evaluation

Referral is the procedure established by the local school district by which a request for a case study evaluation can be made. Referrals may come from a variety of sources. Examples include direct referrals from parents or medical practitioners, or referrals from the outcome of screening activities. It is incumbent upon the LEA to make its procedures concerning referrals general knowledge within its community. The binding requirements around referral, identification, evaluation, and placement of handicapped children are outlined in Article IX of the Rules and Regulations to Govern the Administration and Operation of Special Education.

Assuming that the district determines the referral to be appropriate, a case study evaluation shall be initiated. The case study is a series of multi-disciplinary diagnostic procedures designed to provide information about the child, the nature of the problems which have or potentially will have an effect on that child's educational development, and the type of intervention which seems necessary to alleviate these problems. It should be stressed that evaluating a very young child is a unique task and requires special skills and techniques in observation, relating to children and parents, and interpreting results of testing not necessarily designed originally for very young children. Careful selection of staff and well designed in-service activities can enhance a staff's ability to conduct good evaluations of young children.

Multidisciplinary Conference and Determination of Eligibility for Placement

After a comprehensive case study evaluation has been completed, a multidisciplinary staff conference must be convened to deliberate among appropriate persons, including professionals and parents, whether or not eligibility for early intervention is warranted, and if so, how and what should be provided. The Rules and Regulations to Govern the Administration and Operation of Special Education and The Illinois Primer on Individualized Education Programs (Illinois State Board of Education, June, 1979) should be consulted for timelines and further definition of the stages from referral through determination of the Individualized Education Program (IEP) for the child.

In designing an IEP that meets the needs of an identified young handicapped child, team members should be urged to look at the total child--both strengths as well as weaknesses should be carefully addressed.

EVALUATION

Child find activities need to be evaluated both for purposes of accountability and decision making. However, each specific phase of child find (awareness, location, identification, screening, referral/case study evaluation, staffing and placement) should be evaluated separately. The focus of the evaluation in the child find component should rest largely on process. Are procedures in place to accomplish these various tasks? The overall effectiveness of this effort is determined by documenting that all children have been located and screened and that those with handicapping conditions have been identified for further service. This is, of course, a monumental task but hopefully the guidance given in the Appendix will break it down into manageable portions.

RECOMMENDATIONS

1. Each LEA should, as part of its overall child find activities, have a specific preschool handicapped component.

2. The preschool handicapped component of child find should include, at the minimum, specific sections on awareness, location, identification, screening, and referral through placement.

3. The awareness activities should build on federal and state activities but also include specific local materials/activities.

4. LEAs should develop procedures to determine where specific children are located in their geographic areas.

5. The LEA should have a contact office clearly identified in order to facilitate identification of exceptional preschool children by others outside of LEA personnel (parents, other agencies, physicians, etc.).

6. The LEA should engage in formal screening activities, utilizing some type of standardized instrument(s).

7. The LEA should refer any child it locates to an appropriate program.

8. The LEA should have ongoing data supporting the effectiveness of their child find activities, i.e., do the child find activities make a difference.

9. Each LEA should initiate public information campaigns on 1) service availability, 2) parent and child rights, 3) early intervention, 4) early intervention signs.

10. Each LEA should become completely familiar with Article IX of the Rules and Regulations to Govern the Administration and Operation of Special Education, which deals with identification, evaluation, and placement of exceptional children.

11. Each LEA should understand and be able to articulate the differences between screening and case study evaluation.

Chapter Three
CRITICAL COMPONENTS OF AN EXEMPLARY EARLY CHILDHOOD PROGRAM FOR THE HANDICAPPED

Goal: Each Early Childhood Handicapped Program Should Have Specific Philosophical Statements and Corresponding Functional Objectives and Activities For: Setting, Facilities and Equipment, Curriculum and Instructional Strategies, Parent Involvement, and Personnel

DISCUSSION

In consideration of the critical components of an exemplary early childhood program for the handicapped, five major areas emerge as necessary elements for all programs: setting, facilities and equipment, curriculum and instructional strategies, parent involvement, and personnel. In the following sections an attempt to define and discuss these elements from the perspective of modifications necessary for young children is undertaken. In each section the overriding philosophy is that each element of the educational program should approximate as closely as possible those available or planned programs for young nonhandicapped children. Each element needs to be planned and implemented in order to insure that each child, regardless of the nature or the severity of handicapping condition or set of conditions, will learn or acquire a set of skills necessary to function as independently as possible.

Settings

In designing programs for the young handicapped population, one of the critical components to consider is the appropriate setting in which the handicapped child is to receive his/her educational program. The setting is the physical, instructional and affective/developmental environment in which the child is to receive programming. Current legislation gives strong emphasis to educating handicapped children in the "least restrictive environment," meaning that a continuum of alternative placements should be available to meet the needs of children for special education and related services, and to the maximum extent appropriate, handicapped children should be educated with children who are not handicapped. Secondly, that removal of handicapped children from the regular education environment should occur only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. (Consult the August 23, 1977 Federal Register for rules and regulations applied to implementing Part B of the Education of the Handicapped Act).

The continuum of services which is to be made available includes alternatives such as placement in regular classes, special classes, private facilities, community-based programs, and hospital institutions, and would make provisions for supplementary services.

In making decisions regarding placement in the appropriate least restrictive alternative, it is necessary that placement decisions be made on the basis of individual child needs. Given that few public education programs for three-to-five-year-old nonhandicapped children exist in Illinois, it is especially difficult to make these decisions regarding the appropriate least restrictive alternative for the three-to-five-year-old handicapped population.

Some possible approaches to be considered for providing a least restrictive alternative setting for the young handicapped population, within center-based programs, are:

1. Have special education programs for three-to-five-year-olds located within the regular elementary building and allow the special three-to-five-year-olds to partake in certain kindergarten activities during designated periods of the day/week. Coordinate activities between early childhood and preschool bilingual classes located in the same building by scheduling group activities together, such as field trips, music, art, snacks, physical education, language lessons, etc.

2. Have special education programs for three-to-five-year-olds located in separate facilities specific to the three-to-five-year-old population. Coordinate with local kindergartens in the public school by programming for the three-to-five-year-old special needs children to be with the kindergarten class for specified periods during the week and vice versa.

3. Integrate more severely and profoundly handicapped three-to-five year-olds with less severely involved children. In essence, this endorses the concept of meeting least restrictive environment requirements through coordination internally with special education programs. For the more severely handicapped children, this setting may constitute a least restrictive alternative.

4. Utilize schools which have been abandoned because of declining enrollment as a setting for early childhood special education programs and institute additional programs within the building, such as Head Start, a kindergarten class, youth groups, and other child development programs.

5. Open early childhood special education programs in junior/community colleges/high schools where there are established child development programs for the students, and coordinate programs and activities between the two groups.

6. Coordinate early childhood special education programs (either school facilities or separate facilities) with existing community resources for preschoolers. Dually enroll special needs preschoolers with local Head Start programs for specified days/weeks.

Home-center based programs are programs wherein children receive their primary educational program in the home setting and receive socialization/development experiences and additional educational group activities within a center for a certain specified time per week.

Home-based programs are programs wherein educational and related support services are provided entirely within the home environment (see Chapter Five for a more detailed description).

Both of these programs (home based and home-center based) may be appropriate service delivery options if a local education agency chooses not to sponsor a center based program. Obviously the issues of amount of instructional time, restrictiveness of the educational setting, and quality control of instruction will need to be addressed specifically when using these options.

Facilities and Equipment

In order to fulfill the spirit and intent of accessibility, adequate facilities should be used by early childhood education programs for the handicapped. Basically, all physical structures should be in compliance with Section 504 of the Vocational Rehabilitation Act of 1973 (refer to Section 504 for details). Additionally, State Life Safety Codes, as well as Local Building and Safety Codes should be met. Attention should be given to internal as well as external accessibility. Ramps, covered walkways, width of doorways, toilet facilities, etc., all need to be carefully planned.

All equipment and/or materials for young handicapped children should be developmentally age-appropriate, and specifically designed to meet the handicapping conditions of the child. Priorities should be given to the timely procurement of the equipment that is critical to the instructional needs of the child. It is the responsibility of the teacher and other professional staff that work closely with the child to identify individual equipment needs and an administrative responsibility to meet the identified needs.

Parent Involvement

Good parent involvement components go beyond the letter of the law. They should provide an opportunity for parents to learn about approaches to child-rearing, normal child development, management of the handicapped child in the home, how to be teachers of their own children and how to find and use resources in the community. They should also have direct involvement in decision making, in program planning and operations, and especially in Individualized Education Program development. Provisions should be made for in-classroom participation and parent-to-parent support groups, and parent-designed special activities for themselves and their children.

A parent involvement component should adhere to the same principle of individualization with the parents as is called for in programming for the child, i.e., each parent's desire for participation, involvement, and autonomy needs to be individually examined in designing an effective parent involvement program. In addition, an exemplary program may have a person designated as the Parent Involvement Coordinator for the program, and this person would receive the support, assistance, and cooperation from all other staff so that a coordinated effort would exist.

Rationale for a Continuum of Parent Education Groups

1. To form a supportive climate for families to learn about and share feelings concerning their handicapped child.

2. To provide parents with a means to work through problems in time of emotional stress.

3. To aid parents in understanding their feelings so that they may develop greater competence in dealing with their children.

4. To provide a means for developing parent knowledge in the specific skill areas of child training and management.

5. To provide parents with an opportunity to learn alternative approaches to child rearing.

6. To assist parents in dealing effectively with those individuals within the community that come in contact with their handicapped child.

7. To help parents gain a better knowledge of developmental problems and handicapping conditions by utilizing community resources.

8. To provide a basis for community knowledge and support of the programs for handicapped children.

Research has also indicated the following factors should be considered in the actual planning of parent group education:

1. Parents want to meet and talk with parents who have children with similar handicaps.

2. Parents want parent programs that are structured.

3. Parents want more input from all professionals in their children's programs (e.g., occupational therapists).

4. Parents prefer to deal with their problems with the help of other parents in groups, while with professionals they prefer a one-to-one basis. Experience also suggests that the contact both with other parents going through the crisis period and with "graduate" parents who have made it through the crisis is helpful.

Alternative Approaches to Parent Involvement

Each agency should individualize parent services to meet the needs of families. Regardless of the approach, the support service must be initiated as soon as the handicap is detected. The following list indicates some activities which have been found to be successful.

1. Parent education classes under the sponsorship of adult education or extension. Such classes can be tailored to the specific needs of any early childhood group with content based on the needs and interests of the particular community of parents. The size of an adult education class is a matter for district decision. In general, parent education classes are more effective when they are small and allow for group discussion and interaction.

2. Parent participation classes. In such classes the parents, after a period of orientation, work directly with children in the classroom under the guidance of a teacher skilled in working with both children and adults. A specified period of time each week is spent in a teacher-parent discussion of teaching/learning approaches, developmental needs and strengths of children, and evaluation of individual parent work.

3. Guided observation of children in the classroom. This method provides a visual reinforcement of the teaching/learning activity. As parents view a classroom or group of children in action, they need to be given orientation--opportunity to know what they are observing and what they should watch for with ample opportunity afterwards to discuss their observations, raise questions and receive satisfying answers.

4. Small group meetings. Meetings in homes or other neighborhood locations can reach out to some parents more effectively than a large group or printed pamphlets can. Talking around the table in a neighbor's kitchen may be less threatening, less demanding of any family, and can permit a participant to express feelings and attitudes more freely.

5. Workshops. Parents and school staff together will benefit from such sessions, especially in observing demonstrations, followed by participating, and in the making of home/school teaching devices.

6. Informational meetings. Lectures, film forums, panels, symposiums, etc., may be established by the school on a volunteer or informal basis or under adult education. Discussions should be led by skilled persons.

7. Parent-teacher conferences. Such conferences are a strong asset when their content is clearly related to the objectives of the program for parents and children. Usually, the most constructive conferences are those which are scheduled. Informal conferences in the corridors or on the playground may be excellent take-off points. Such informal conferences should be followed up in most instances with more focused parent-teacher discussion without distraction.

8. Home visits. Visits can be used both for parent-teacher conferences and a way of providing instruction or demonstration in educational home activity. A home visit is a professional function to be used for the purpose of reaching program goals and should never be made to satisfy personal curiosity or to fulfill a requirement.

9. Informational materials. These should be a part of every parent education component. The development of a school-parent lending library will be of much value to some parents. Many PTA units started and continued such libraries in the last two decades and a nucleus of materials may still be available in some schools. Media presentations may be preferred and these might be offered by various audio-visual media, or educational television or radio. Publications, newsletters and individual correspondence might be considered to supplement group parent programs.

Curriculum and Instructional Strategies

The curriculum and instructional strategies utilized by exemplary early childhood education programs should follow directly from the goals and objectives specified in the Individualized Education Program. Both should be stated explicitly in behavioral terms to insure efficient data based evaluation. Further, both curriculum and instructional strategies should be individualized for each student. It is highly unlikely that existing curricula for young handicapped children can be applied without modification.

The ultimate criteria by which one is to judge the effectiveness of a curriculum and instructional strategies are twofold. First, the content of what is taught should be developmentally relevant to the ultimate life functioning of the individual. Second, any approach which can be demonstrated objectively to have resulted in the attainment of individual skills and does not infringe upon the rights of the child is to be preferred.

Choice of the specific components of a curriculum for the young exceptional child should depend upon a number of factors. As stated above, primary among the factors is a careful consideration of those skill areas needed by any individual in order to function as independently as possible. At the minimum this would include communication, motor skill, self-help or socialization skills, and cognitive skills necessary to deduce solutions to everyday life problems. These areas emerge from the simple recognition that any person must be able to communicate his or her needs and wishes in as understandable a fashion as possible, move from one place to another in an efficient manner, interact with others in an adaptive functional way, and derive solutions to new problems. Additional skills (for example, visual discrimination, auditory and visual memory, etc.) should be taught in the context of the above mentioned critical domains.

While listing of specific skill domains does provide the skeletal content of curriculum, a further refinement is necessary. Within each domain teachers should refer to empirically verified sequential lists of subskills. There is ample research to indicate that skills do not develop in isolation but rather build one upon the other. The validity of such a statement can be further verified by the simple consideration of the logical necessity of complex competencies building upon earlier emergent simpler skills. Such developmental approaches offering the teacher a very helpful tool to curriculum development have resulted in a variety of lattices or flow charts which specify the sequencing of subskills within curriculum domains. Thus, by referring to such ordered lists it is possible to determine where the ability of the handicapped child first breaks down or where he/she cannot perform to criterion. Teaching then begins at the first subskill not mastered. Lattices, flow charts and/or developmental lists when used judiciously can guide both the content of instruction and the sequence in which subskills are to be taught.

The word "judicious" is to be emphasized. By its use it is meant that such sequences (most often derived from observation of nonhandicapped child development) may include subskills which are either not critical or are unattainable for a particular child. For example, the subskill "walks upstairs one step per tread" may not be possible for the extremely motorically involved child nor as stated is it necessary. Ramps, elevators, etc., may completely eliminate the necessity for such skill. It thus should be eliminated from the list. Any skill not critical to the ultimate attainment of a goal should not be taught.

A developmental approach with its convenient lists of subskills may provide teachers with content, but instructional strategy of "how to teach" is as important. Several general principles of effective instructional strategies are:

1. In order to learn, the child needs to be motivated to do so and rewarded for success.

2. Instructional programs should be designed so that learner failures (incorrect responses) can rarely occur.

3. The learner should always be an active participant in the instructional program, not a passive recipient of information.

4. Learners should practice acquired skills in a variety of settings and with a variety of people.

5. Learners should be taught not just to perform skills but to do so at an acceptable rate and soon after being requested to do so.

6. Meaningful (familiar) materials and tasks are preferred over less meaningful materials and tasks.

7. As many other individuals significant to the child should be actively involved in both the planning and implementation of instruction as possible, including parents, siblings, relatives and friends.

The above list is not meant to be comprehensive but merely representative of the kinds of principles to which one should adhere when selecting a strategy. They are, however, completely consistent with what has been termed a "Task Analysis" approach to instruction, and the general set of principles of the applied analysis of behavior.

A final consideration is that whenever possible groupings of children should be based upon a careful determination of programmatic and educational needs, and not on the basis of disability.

Personnel

All early childhood programs for the handicapped, to be effective, need qualified staff. Implicit in this statement is the need for hiring appropriately trained staff and for providing systematic inservice training (see Chapter Four).

However, even after the appropriate staff are hired, careful thought should be given relative to the most efficacious utilization of the personnel. The effective utilization of staff, both direct service (teachers, parents, teachers' aides, teacher assistants, volunteers, student teachers, psychologists, speech therapists, physical therapists, occupational therapists, nurses, medical doctors, social workers, parent involvement coordinators, audiologists and others) as well as support staff (administrators, supervisors, maintenance, clerical, transportation, secretarial, etc.), is critical to the effective functioning of an exemplary early childhood program for handicapped children.

Three models frequently employed for staff utilization are: multidisciplinary, interdisciplinary and transdisciplinary. In the multidisciplinary model each professional interacts with the child in relative

isolation, sharing information with other professionals only rarely and then most often in the context of formal meetings. In the interdisciplinary model there is more sharing of information, but role definitions and areas of responsibility are rigidly adhered to. Professionals may work together when seeing children but their behavior reflects a "taking turns" approach. The third approach and the one to be preferred is the transdisciplinary approach in which there is both a sharing of information and, through reciprocal training, an actual sharing of roles. To further distinguish between the multi and interdisciplinary, and the transdisciplinary approaches, in the first two instances the responsibility for direct service to the child is shared to varying degrees by the representatives of the various disciplines. In the transdisciplinary approach, the child's parent(s) and teacher(s) are viewed as the primary direct service personnel, since they are likely to have more contact with the child than anyone else. Supportive service personnel (physical and occupational therapists, language therapists, etc.) assist in meeting the needs of the child by playing three roles. The first is a consultative role. The specialist is brought in specifically because of his/her expertise to provide professional advice and counsel to the parent(s) and teacher(s) based on the unique needs of the child. The specialist then assumes the second role of trainer. He or she must train the parent(s) and teacher(s) in those specialized skills and techniques which are required to effectively carry out the child's individualized program. The specialist is responsible not only for training the parent(s) and teacher(s) as to how to implement special techniques and intervention strategies, but also should document the effectiveness of the training efforts. Not only should effectiveness of the training be determined initially, but periodically checks should be made by the specialist to determine if the skills learned by the parent(s) and teacher(s) are being maintained as they interact directly with the child.

The third role of the specialist is the maintenance of the more traditional role of providing direct service to the child. This role is only used when the technique or service to be provided is so unique or specialized that it is all but impossible to expediently and effectively communicate through consultation and training of the parent(s) and teacher(s). Additionally, for some types of specialized therapies and evaluations only the appropriately licensed or certified specialist can legally provide that service. In these cases the specialists continue to provide direct services to children. Two clear advantages of the transdisciplinary approach are that, first, the children benefit both from a broader exposure to expertise and from a greater involvement and thus committment from all staff and, secondly, it is cost effective from the perspective of more productive utilization of staff time. Well trained staff, appropriately utilized, ensure effective programs for young handicapped children.

Intimately related to these issues is the concept of successfully transitioning early childhood special needs children into the kindergarten and primary programs. Following are various alternative strategies for providing smooth transitioning of young handicapped children into the kindergarten and primary programs:

1. Kindergarten and primary teachers who will receive special children visit the program, observe current functioning of children, and talk with teachers and parents. An annual "open house," attending inservices concerning early childhood education for the handicapped, as well as periodic visits to the early childhood program will facilitate this process by familiarizing the kindergarten and primary teachers with the special needs children and their programming.

2. The early childhood special education teacher should be allowed time to provide on-site inservice to the kindergarten and primary teachers receiving young handicapped children from the early childhood programs at the beginning of the school year. The purpose would be to assist the new teacher in working with the child, acquainting him/her with any specific techniques or methods which proved particularly successful in the early childhood program, and to provide a measure of continuity for the child as he/she leaves early childhood and enters the elementary school system.

3. Kindergarten/primary teachers who will be receiving the young handicapped children during the following year should be included in the annual review staffings which establish the IEP goals for the following school year. This would familiarize them in advance with the child's functioning, educational needs, and prerequisites.

4. Early childhood special education teachers and kindergarten teachers should determine from the public school system what basic skills/competencies will be expected from the children as they leave early childhood programming and enter kindergarten and primary programs. In this way, early childhood curriculum can be more goal directed and appropriate educational linkages can be made between early childhood, kindergarten, and primary education levels.

EVALUATION

These five components (setting, facilities and equipment, curriculum and instructional strategies, parent involvement, and personnel) form the basis for effective programming. Obviously careful planning is required for these components to be successful. A critical part of this planning is ongoing evaluation. The obvious desired outcome of all these components is increased child performance. Therefore, questions such as: what are the effects of specific materials on child performance?; are the facilities adequate for learning?; is there a need for additional or different staff?; is the curriculum appropriate? etc., are all dependent on a well developed evaluation strategy. Although there are many specific strategies that can be used, several evaluation principles are important (see Appendix A). The evaluation design should include some form of child performance data. Data collection should be ongoing and not static. The data that are collected should be used to make program decisions. Regardless of method, precise, continuous evaluation strategies are an absolute neccessity for effective programming.

RECOMMENDATIONS

1. A continuum of service options should be available for providing appropriate educational programs for young handicapped children.

2. Personnel for young handicapped children should be adequately trained and available to meet the individual needs of each child. School districts should be moving toward a transdisciplinary model for personnel utilization.

3. Curriculum and instructional strategies should be designed in a multidisciplinary fashion to provide the most efficient and effective instructional programs for each child.

4. Appropriate facilities and sufficient equipment should be available to meet the needs of young handicapped children.

5. Parental involvement should be an integral component of all early childhood handicapped programs.

Chapter Four

PERSONNEL PREPARATION AND STAFF DEVELOPMENT

Goal: To Adequately Prepare and Provide for the Continuous Staff Development of Early Childhood Educators

DISCUSSION

Although preschool education for handicapped children, three through five years of age, has been mandated in Illinois since 1972, some school districts are not adequately serving young handicapped children. The issues raised to explain this situation are as varied as the programs within the districts. Most explanations reflect a lack of understanding regarding the importance of early intervention with young handicapped children.

There are several possible reasons for this attitude or opinion. First, this is the first time that many school personnel are dealing with the three-through-five year old population. The school system is designed to normally accommodate children aged five through seventeen. It is not organized to deliver services to young handicapped children or their parents. Second, many school personnel lack the knowledge of how to integrate these children into the existing service delivery system. Third, they have little background in programming for these children or in selecting personnel qualified to work in early childhood programs for the handicapped. Fourth, some school personnel lack an understanding of the importance of parent (or care-giver) participation and the knowledge of how to effectively involve parents in the educational process. However, untrained or inexperienced personnel can no longer be used as an excuse of inadequately serving young handicapped children. The Education for All Handicapped Children Act (P.L. 94-142) clearly specifies that a comprehensive system of personnel development be a component of each State Plan.

The purpose of this section is to specify the critical issues and concerns that relate to the preparation of personnel to work with preschool aged handicapped children, and their parents. Although much of the chapter addresses the training needs of the teaching staff, personnel is defined as including administrative, supervisory, teaching, ancillary and support staff. Personnel preparation is viewed as an ongoing process of professional development rather than a series of short term training activities which culminate with the award of an academic degree.

The Need for Transdisciplinary Preparation

The unique characteristics of an early childhood program for handicapped children warrants some discussion in view of the training competencies required at the preservice level. No other area of special education is dominated by the wide range and severity of handicapping conditions resulting in a variety of ability levels. Due to the noncategorical approach to placement and programming for these children, it is not uncommon for an early childhood classroom for the handicapped to include children exhibiting a wide variety of functional skills.

In many districts the responsibilities traditionally assumed by the administrative, support and resource personnel rest in the hands of the classroom teacher. It is not uncommon for the early childhood educator of the handicapped to be responsible for tasks ranging from awareness and child find to parent counseling and program evaluation. Often these "assignments" are conducted with little or no outside supervision. The early childhood educator of the handicapped is expected to be a professional of all disciplines--administrator, supervisor, teacher, counselor, language expert, motor therapist, child advocate, etc. This expectation is unrealistic from a practical viewpoint, but many districts seem to assume that part of the job description of an early childhood handicapped educator includes doing the impossible.

The need for transdisciplinary training. These varied responsibilities necessitate preparing early childhood personnel to work with other professionals in providing services across traditional discipline boundaries. This transdisciplinary model requires personnel to effectively interact and communicate with fellow colleagues, support staff, resource persons, administrators and parents in both a consulting and training capacity. The successful utilization of ancillary classroom staff, i.e., aides, parents and student trainees as program implementers, is an essential practice for operationalizing such a model.

Matching training models with service delivery models. Personnel preparation programs that train individuals to work with young handicapped children and their parents are faced with several problems. Early childhood handicapped trainees need to possess knowledge and demonstrate skills in several discipline areas. This notion requires trainees to complete field-based experiences in settings that provide multidisciplinary services in a manner which permits role release among the participating professionals. Most public schools, as they presently exist, are not organized to deliver services in this manner.

The need for uniform training competencies. A further complication is the lack of an existing bank of early childhood handicapped training competencies to serve as a base for personnel preparation programs. The Illinois state requirements for approval of educators to teach young handicapped children (necessary for reimbursement) currently lack the specification of appropriate training competencies. As a result, each personnel preparation facility attempts to design and implement a training program to meet state early childhood handicapped approval requirements but does so with little guidance or direction from the state. Consequently, an employer can only assume that a newly approved early childhood educator of the handicapped possesses a minimal level of knowledge and skill competencies in the critical areas of early childhood education for the handicapped.

Identifying uniform competencies. It is virtually impossible to enumerate with any specificity the multitude of competencies that are appropriate to each professional and those that transcend discipline areas. Therefore, categories of competencies have been identified here that individuals should have an awareness or knowledge about, and/or practical expertise in, when they work with young handicapped children and their parents. The ideal competencies of the administrative, teaching, support and resource staff were considered in generating this list.

Four major components of Early Childhood Education for the Handicapped--Assessment, Programming, Consultation/Training, and Child/Family Advocacy--are highlighted. The categories of minimal training competencies listed under each component area further specify necessary training skills.

Categories of Minimal Training Competencies

I. Assessment
   - A. Child find procedures
   - B. Criterion-referenced and norm-referenced measurement
   - C. Classroom diagnostics
   - D. Observational recording
   - E. Case study

II. Instructional Planning, Implementation and Evaluation
   - A. Development of IEPs
   - B. Normal child development
   - C. Behavior management
   - D. Instructional delivery
   - E. Task analysis
   - F. Adaptation of instructional materials and curricula
   - G. Curriculum development
   - H. Staff utilization
   - I. Participation in transdisciplinary model
   - J. Program management
     1. motor (mobility, gross and fine)
     2. sensory or perceptual
     3. communication
     4. socialization
     5. self-help
     6. cognition
   - K. Evaluation of instructional materials and curricula

III. Case Management
   - A. Work with families
   - B. Train classroom support personnel
   - C. Function as a team leader
   - D. Work with community agencies and service providers

IV. Child and Family Advocacy
   - A. Knowledge of federal laws
   - B. Knowledge of state rules and regulations
   - C. Knowledge of LEA organization and procedures

Levels of Skill

It is unreasonable to expect that every individual involved in the implementation of an early childhood handicapped program requires the same level of knowledge and skill in each of these areas. For example, one expects a teacher to exhibit the expertise necessary to delineate an appropriate instructional objective and to sequence the component skills of that objective for a given child. It may be sufficient for the occupational therapist, however, to possess a working knowledge of the instructional sequence for

teaching a cognitive task, and for the Director of Special Education to have a general awareness of the instructional methods implemented in the district's programs. The distinction made between awareness (general knowledge) understanding (the ability to discuss the item intelligently) and expertise (expert skill in a particular area) involves the degree of proficiency necessary to successfully execute the responsibilities of a given job.

These three levels of knowledge and skill acquisition--awareness, working knowledge, and expertise constitute a hierarchy of training competence. This hierarchy can be used to specify the level of competence various individuals working with young handicapped children should possess in each training area (see Training Competency Grid).

Training Competency Grid

The following grid displays the suggested levels of training competence for personnel working with young handicapped children and their parents. For the sake of brevity and clarity, a "typical" early childhood handicapped program staff is used to illustrate this example. The terms "administrative", "teaching", "support", and "resource" are defined as follows: administrative includes those individuals who are responsible for program administration and staff supervision; teaching identifies the persons who direct the educational experiences of the child and parents; support describes the multidiscipline professionals who cooperatively plan, implement, and evaluate the child's education programs; and resource includes the persons who assist the direct service personnel in specified tasks for limited periods of time, i.e., community volunteers, bus drivers.

The exclusion of the child's parents from the list of personnel should not be construed as a rejection of the parent as a team member. On the contrary, the parent is perceived as an integral participant in all aspects of program planning, implementation, and evaluation. As such, the parent can assume, or be trained to perform, the function of any discipline speciality working with the child.

The Training Competency Grid also can be a guide in the selection of skills for both the preservice and the inservice training across a wide range of competencies (assessment, instructional planning, training, consultation and child/family advocacy) and a wide range of acceptable performance (awareness, working knowledge, and expertise). In addition, it can provide recommended knowledge and skill information to those persons responsible for the screening and hiring of early childhood handicapped program staff.

Inservice Training

Given the numerous training needs of early childhood handicapped personnel and the limited time period of any preservice program, it is essential to view personnel preparation as a continuing process from preservice training through ongoing staff development. An inservice program can both fulfill the unmet preservice needs and provide more sophisticated training to experienced personnel. Inservice programs that are interfaced with the training offered through personnel preparation programs can provide this continuum of training needs.

Issues. Presently, many inservice programs are organized according to the number of available institute days rather than on the needs of the staff. Inservice programs are viable when they are directed to the participant's level of predetermined need--awareness, knowledge and/or training; the training outcomes are specified; and the participants are afforded the opportunity to critique the content of the presentation and to furnish feedback to the presenter. These activities provide a systematic approach to identify training needs, to plan and to implement the inservice activities and to evaluate the inservice program.

Use of in-house personnel. In many instances, in-house personnel effectively can meet local inservice needs rather than relying on outside experts. Utilizing the skills of existing staff members for training and consultation with each other supports the transdisciplinary approach to service delivery. This plan of inservice training encourages the development of a network of in-house experts that are available to the entire staff on a continuing basis.

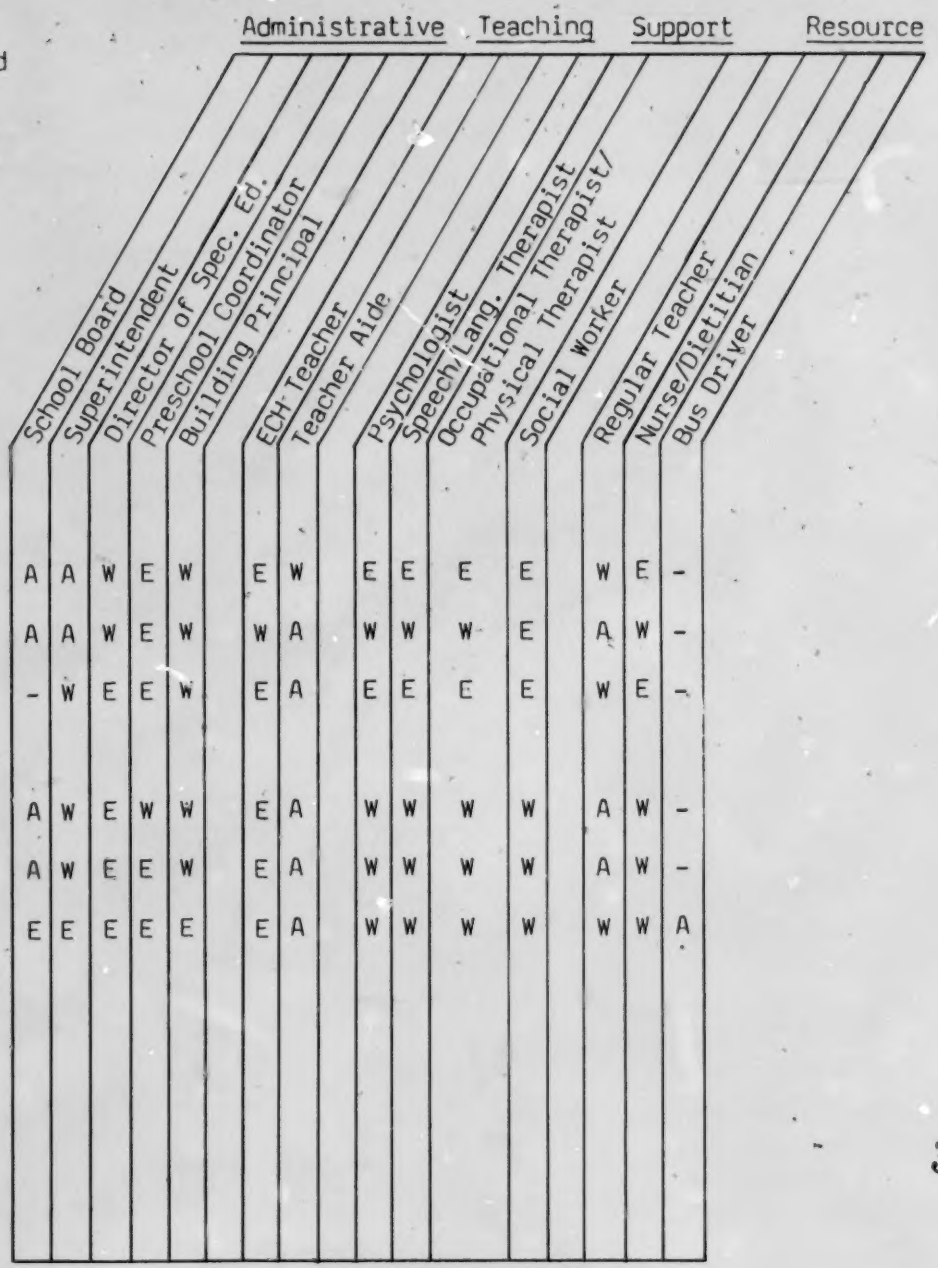
University and LEA joint training efforts. When it is necessary to seek outside expertise, university/college personnel can be utilized as a source of multidiscipline consultations. An ongoing, cooperative inservice training effort can be advantageous both to the school district and the university/college. The state teacher training institutions are charged with the responsibility of providing programs for continuing inservice/staff development. If school districts are involved in the formulation and implementation of their staff development program, then university/college sponsored activities should be more meaningful and appropriate to LEA personnel. This could be accomplished by inviting the participants to inform prospective resource people of their training needs, their desired level of participation in the staff development program, and any other relevant information which describes their situation, i.e., possible meeting times, number of group members, etc.

By providing this information prior to the initiation of an inservice/staff development activity, the presenters can organize the task to make maximum use of their expertise.

EVALUATION

Preservice Training. The rising educational expectations of teachers by the tax paying public and the increasing cost of higher education have directed increasing attention to the result of teacher training. Although teacher educators traditionally have been concerned with the result of personnel preparation, i.e., graduates' successful job performance as teachers, the focus of praise or blame has fallen on the new teacher rather than on the university/college personnel preparation programs. Trainees are becoming increasingly resistant to accepting the sole responsibility for their often inadequate job preparation, and are intolerant of teacher trainers who fail to provide them with appropriate preservice training experiences. Taxpayers, too, are now demanding measurable results.

Training Competency Grid

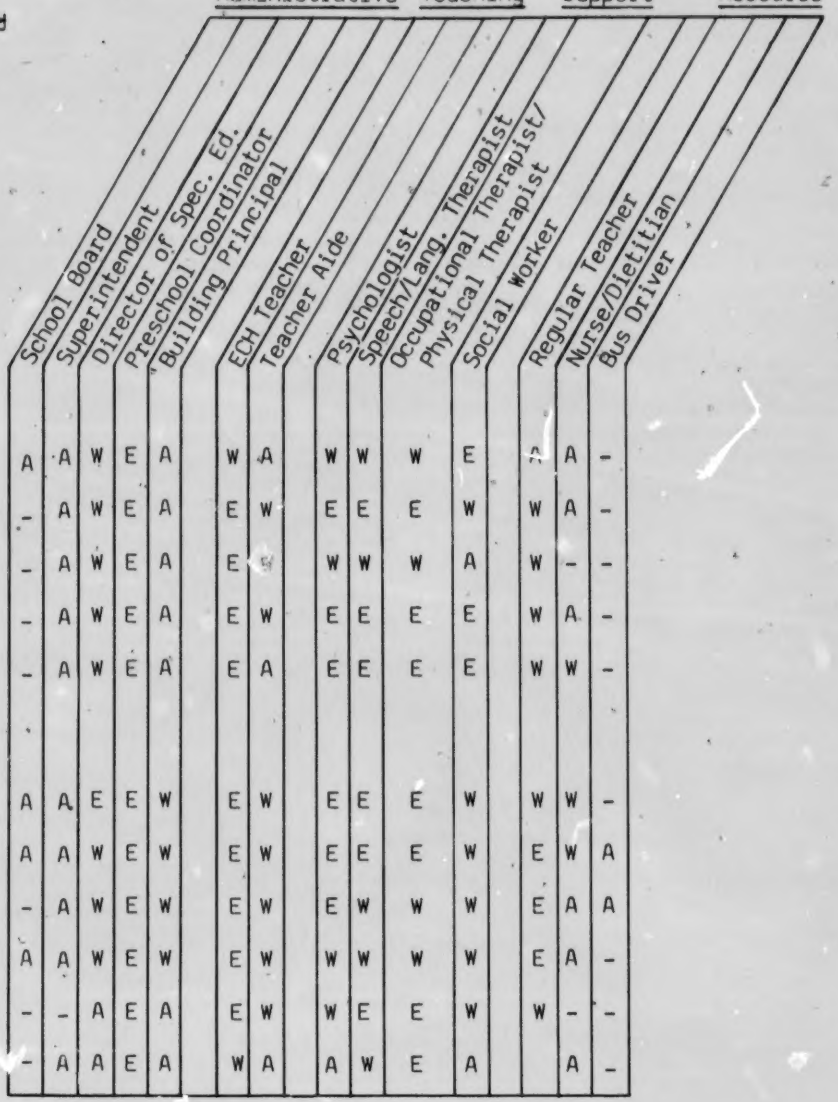


Minimal Training Competencies

CASE MANAGEMENT															
Caregiver/parent training	A	A	W	E	W		E	W		E	E	E	E		W	E	-
Coordination with community agencies	A	A	W	E	W		W	A		W	W	W	E		A	W	-
Direct inservice	-	W	E	E	W		E	A		E	E	E	E		W	E	-
CHILD AND FAMILY ADVOCACY															
Knowledge of federal law	A	W	E	W	W		E	A		W	W	W	W		A	W	-
Knowledge of state rules/reg.	A	W	E	E	W		E	A		W	W	W	W		A	W	-
Knowledge of school district structure	E	E	E	E	E		E	A		W	W	W	W		W	W	A

A = Awareness
W = Working Knowledge
E = Expertise
- = Not Applicable

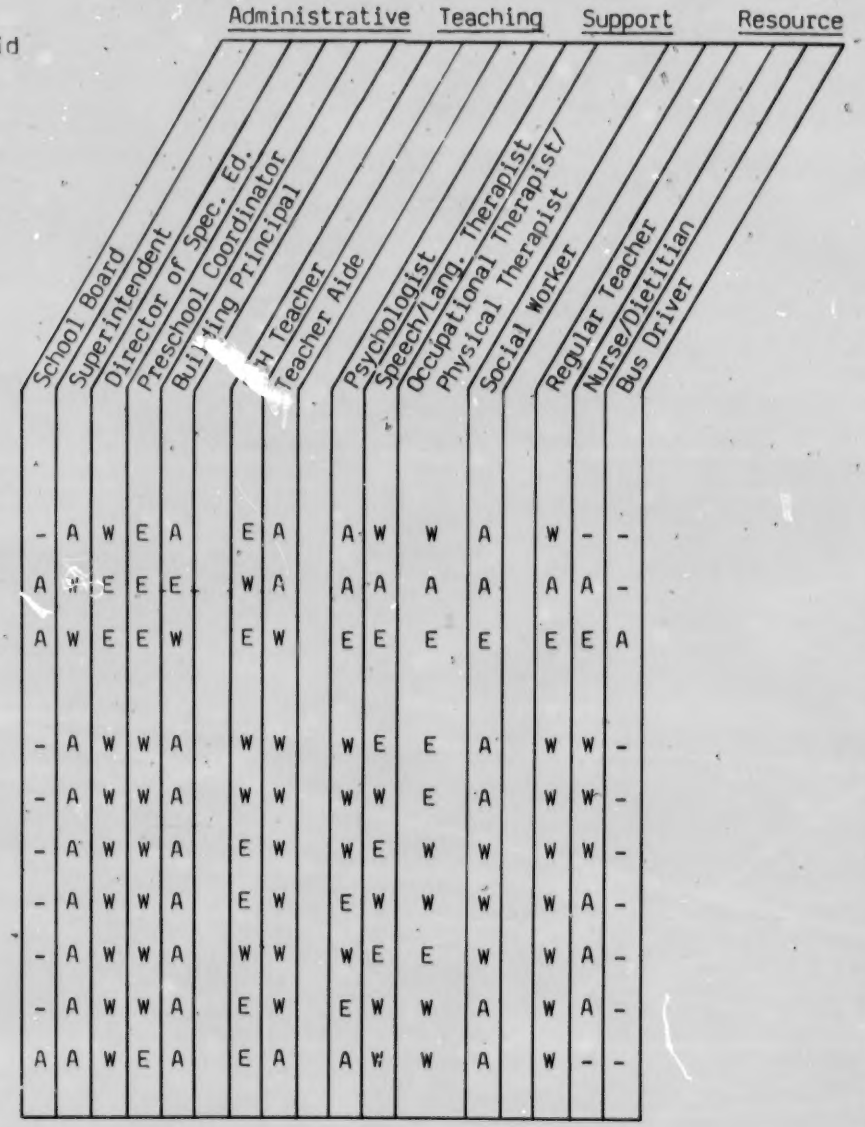
Training Competency Grid



Minimal Training Competencies																
ASSESSMENT																
Child find procedures	A	A	W	E	A		W	A		W	W	W	E		A	-
Criterion ref./norm. ref. measurement	-	A	W	E	A		E	W		E	E	E	W		A	-
Classroom diagnostics	-	A	W	E	A		E	W		W	W	W	A		-	-
Observational recording	-	A	W	E	A		E	W		E	E	E	E		A	-
Case study	-	A	W	E	A		E	A		E	E	E	E		W	-
INSTRUCTIONAL PLANNING, IMPLEMENTATION AND EVALUATION																
Development of IEPs	A	A	E	E	W		E	W		E	E	E	W		W	-
Normal child development	A	A	W	E	W		E	W		E	E	E	W		W	A
Behavior management	-	A	W	E	W		E	W		E	W	W	W		A	A
Instructional delivery	A	A	W	E	W		E	W		W	W	W	W		A	-
Task analysis	-	-	A	E	A		E	W		W	E	E	W		-	-
Adaptation of instructional materials/ curricula	-	A	A	E	A		W	A		A	W	E	A		A	-

A = Awareness
W = Working Knowledge
E = Expertise
- = Not Applicable

Training Competency Grid



Minimal Training Competencies

INSTRUCTIONAL PLANNING, IMPLEMENTATION AND EVALUATION (continued)															
Curriculum development	-	A	W	E	A		E	A		A	W	W	A		W	-	-
Staff utilization	A	W	E	E	E		W	A		A	A	A	A		A	A	-
Participation in transdisciplinary model	A	W	E	E	W		E	W		E	E	E	E		E	E	A
PROGRAM MANAGEMENT															
Motor (mobility, gross and fine)	-	A	W	W	A		W	W		W	E	E	A		W	W	-
Sensory or perceptual	-	A	W	W	A		W	W		W	W	E	A		W	W	-
Communication	-	A	W	W	A		E	W		W	E	W	W		W	W	-
Socialization	-	A	W	W	A		E	W		E	W	W	W		W	A	-
Self-help	-	A	W	W	A		W	W		W	E	E	W		W	A	-
Pre-academic	-	A	W	W	A		E	W		E	W	W	A		W	A	-
Eval. of instruc. mat'ls and curricula	A	A	W	E	A		E	A		A	W	W	A		W	-	-

A = Awareness
W = Working Knowledge
E = Expertise
- = Not Applicable

This change in attitude is reflected in numerous accountability stipulations imposed on personnel preparation programs receiving federal dollars. For example, the Bureau of Education for the Handicapped (BEH) requires applicants to design evaluation plans that assess both trainees' progress and overall program development.

If one begins to accept the discussion on the previous pages regarding the acceptance of competency-based teacher performance, then the performance of these competencies becomes a natural yardstick by which the impact of teacher training programs can be measured.

Inservice Training. In order to assess the effectiveness of an inservice training program, there should be information available regarding the inservice participant's entry level of knowledge and skill. An assessment of the intended audience's training competencies provides this baseline information. Once this information is obtained, the program's effectiveness can be ascertained through the use of two types of evaluation--formative and summative.

As individual inservice activities occur, data can be collected via questionnaires, rating scales, and interviews from program participants. The information gathered by using this formative evaluation procedure can provide feedback for program improvement on a continuing basis. This method also can be used to document areas of program strength or weakness and to provide evidence for the justification of a program change.

A summative evaluation, by contrast, can serve to assess the impact, efficiency and adequacy of the entire inservice program. Information gathered during this evaluation phase can be helpful in making decisions regarding the best procedures and practice to use in future inservice training programs.

RECOMMENDATIONS

Based on the information presented regarding both preservice and inservice approaches to early childhood handicapped personnel preparations, the following recommendations are proposed:

1. Personnel preparation should be viewed as a continuing process from preservice training through ongoing staff development.

2. Personnel preparation programs should be designed to train individuals in working with handicapped children, birth through five years of age, and their parents.

3. The number of preservice training competencies should be limited to those that are essential for successful job performance. Inservice training can be used to extend the unmet preservice needs, to refine existing skills, and to develop more sophisticated methods of assessing, programming, training and consulting.

4. The unique combination of skills required of the early childhood handicapped personnel strongly suggests a transdisciplinary approach to preservice and inservice training.

5. Professionals representing the various disciplines involved in serving young handicapped children should be involved in the training of early childhood handicapped personnel.

6. Coursework at both the preservice and inservice stages of training should be interfaced with supervised, ongoing practica.

7. The effectiveness of both the preservice and inservice training can be evaluated by the demonstrated performance of the competencies in the natural setting.

8. Cooperative training efforts between the personnel preparation facilities and the public schools need to be established. In many instances, the universities/colleges should assume the responsibility for initiating this interaction.

Chapter Five

BIRTH-TO-THREE SERVICES

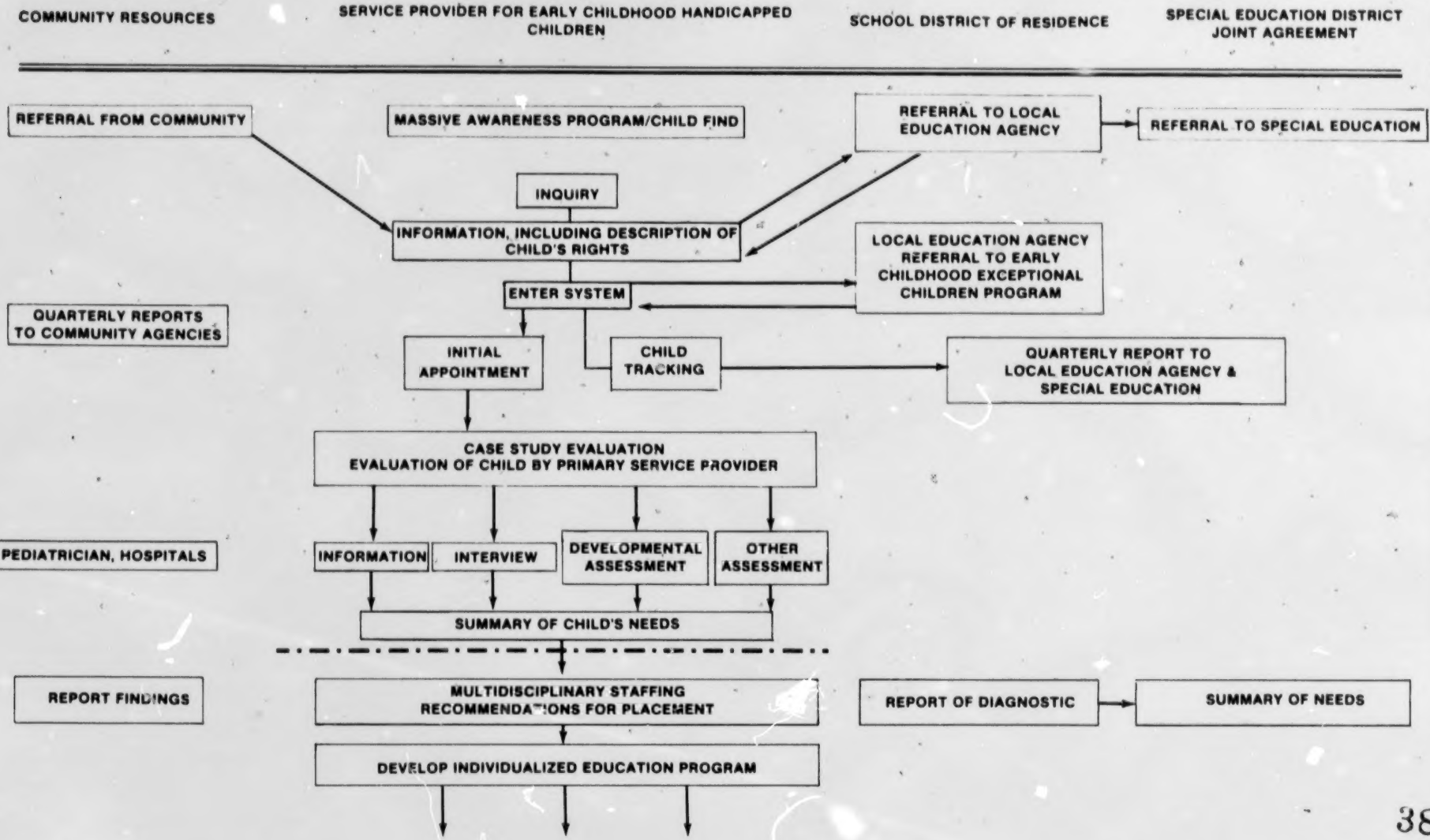
Goal: To Facilitate the Provision of Educational and Related Services to Handicapped Children Ranging in Age from Birth to Three Years

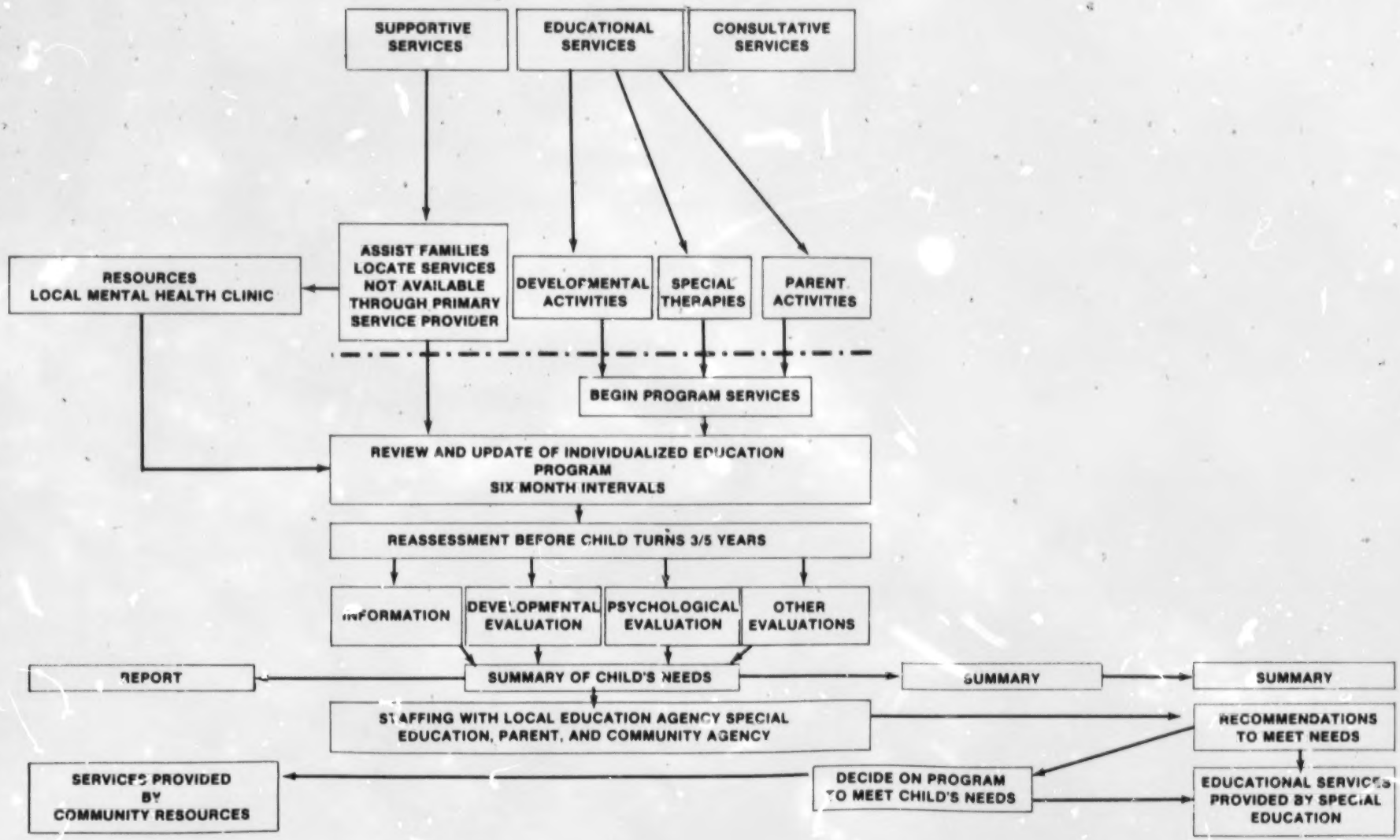
DISCUSSION

The provision of educational and related services to handicapped infants and toddlers is certainly as complex as to three-to-five year olds, and perhaps even more unique due to the fact that the provision of services to birth-to-three years olds is an even newer concept. To add to the complexity, no single agency has mandated responsibility for provision of services to this group of children. As a result, service availability, quality, and comprehensiveness vary across the state. Although a new field, there are certain issues that seem rather clear: programs need to be individualized to the child's and his/her family's needs; a variety of services will likely be needed and can be provided through a transdisciplinary approach; and that meaningful parent/family involvement is usually an essential component of a quality infant (birth-to-three) program.

The flow chart which was presented at the beginning of Chapter One is repeated here. The reader is encouraged to examine the process which is depicted before reading the rest of the chapter, since the chart should help to bring the total service model into perspective. In reviewing the chart it will be apparent that the programmatic process should be the same regardless of what agency provides the service (or has primary responsibility to see that services are provided) - be it the public school, a residential program, a community based private facility, or any other agency. The center column of the flow chart, "Service Provider for Early Childhood Handicapped Children" illustrates the components necessary for providing ongoing, comprehensive services. The discussion following the flow chart will address various components of the process.

PROCESS MODEL FOR DELIVERY OF SERVICES TO EARLY CHILDHOOD HANDICAPPED CHILDREN




SUPPORTIVE SERVICES
EDUCATIONAL SERVICES
CONSULTATIVE SERVICES
RESOURCES LOCAL MENTAL HEALTH CLINIC
ASSIST FAMILIES LOCATE SERVICES NOT AVAILABLE THROUGH PRIMARY SERVICE PROVIDER
DEVELOPMENTAL ACTIVITIES
SPECIAL THERAPIES
PARENT ACTIVITIES
BEGIN PROGRAM SERVICES
REVIEW AND UPDATE OF INDIVIDUALIZED EDUCATION PROGRAM SIX MONTH INTERVALS
REASSESSMENT BEFORE CHILD TURNS 3/5 YEARS
INFORMATION
DEVELOPMENTAL EVALUATION
PSYCHOLOGICAL EVALUATION
OTHER EVALUATIONS
REPORT
SUMMARY OF CHILD'S NEEDS
SUMMARY
SUMMARY
STAFFING WITH LOCAL EDUCATION AGENCY SPECIAL EDUCATION, PARENT, AND COMMUNITY AGENCY
RECOMMENDATIONS TO MEET NEEDS
SERVICES PROVIDED BY COMMUNITY RESOURCES
DECIDE ON PROGRAM TO MEET CHILD'S NEEDS
EDUCATIONAL SERVICES PROVIDED BY SPECIAL EDUCATION

The educational model presented in the chart is based on a developmental task analysis approach to individualized prescriptive teaching which is also applicable to the three-through-five year old population. It reflects the premise that the multiple needs created by a child's handicapping conditions warrant the active participation of a transdisciplinary team, cooperating to develop and continually adjust the child's developmental program. The team may include (but is not limited to) representatives from occupational therapy, physical therapy, speech/language therapy, medical services, psychological services, social work, and child development. The role of this team for infant programming is seen as diagnostic as well as programmatic. Each discipline contributes to the overall program for the home and the center, rather than fulfilling a traditional role of providing individual therapy. Each team member assists in training other team members to understand and implement aspects of a particular discipline (see Chapters Three and Four). This approach is important since it is projected that children served in infant programs might exhibit medical, psychological, and educational handicaps, and/or high risk factors (that is, factors that would make that child more likely to develop some type of handicap).

Awareness, location, identification, and screening are all considered critical to the provision of services to infants and toddlers. Chapter Two of this document discusses these components and may also be applied to this age span. Reference to Chapter Two will be helpful in planning and implementing programs for this population.

Coordination

With regard to the process of service delivery, it is likely that numerous public and private agencies may be involved to meet the needs of the infants and their families. From the point of initial referral a system is required to coordinate contact between these agencies to insure that families are not bombarded by several different agencies. Negative results of failure to coordinate across agencies include segmented services, duplicated services, or unavailable services. Each of these results is likely to unnecessarily frustrate and discourage the family.

Initial Contact

From the initial contact with the family, careful consideration needs to be given to a variety of issues. Parents' emotional needs relative to understanding and coping with the child's handicap are to be considered. Assurance should be available to the parents that appropriate programs or resources are available. Clear, concise information and explanation should be provided families concerning the nature and degree of the handicapping condition. It is helpful if one staff member is assigned as case manager to coordinate the child's services. Based on the needs of the parents, early entry into parent groups is often valuable. Again based on family needs, the feasibility of providing respite babysitting services may be explored. Case study evaluations will be needed in order to carefully plan an individualized program, and may include (but not be limited to) developmental profile, social/medical history, speech and language evaluation, psychological evaluation, audiometric screening, vision screening, medical evaluation, and occupational/physical therapy evaluation.

Multidisciplinary Conference

Regardless of which agency assumes primary responsibility for service delivery to any given birth-to-three year old, it will be necessary for a conference to be scheduled upon completion of all the child's evaluations. All pertinent data should be summarized and brought to the conference. Participants in the conference will be the parents, those persons who had direct contact with the child during the evaluation process, and those who will be directly involved in program implementation. All program options available to the child should be discussed, with the most appropriate being selected. These options may include home-based, center-based, or a combination of home and center-based service delivery. The child's individualized education program (or individualized service program) is written during this conference containing information about the nature of the intervention to be provided, the action that will be required to implement the intervention, and plans to modify the program at frequent intervals with the participation of all concerned.

Service Delivery Alternatives

The delivery of services to birth-to-three year old handicapped children occurs most frequently in one of three setting designs: home-based, center-based, or a combination of home and center-based. The child's needs, the family's needs, and the availability of program options may all contribute to the determination of which design will be used.

The home-based approach is intended to deliver the educational program to the child and family in the home, which is generally considered the "natural" environment for this age range. A staff person, sometimes known as a parent-infant educator, goes to the child's home to assist in enhancing the child's development as well as to assist parents to become the primary educators of their infant. Often, objective data-keeping is used to note growth over a period of time which helps document the child's movement toward his/her maximum potential and strengthens the family's confidence in its ability to help the child.

The combined home and center-based approach is another alternative for service delivery. In this approach the handicapped child and parent(s) come to a center for a designated number of sessions each week, with a specified length of time for each session. As in the home-based approach, the parent(s) is involved in the delivery of the child's individualized program. Additionally, the family is served in the home an established number of times each month. This insures that the parent(s) has direct influence on the child's educational development. In the home environment the parents' belief in their abilities to be the primary "educators" of their child is enhanced.

In selecting this type of service alternative a number of factors should be considered, including: geographic location of the program (center and location of homes of families to be served), working patterns of parents, the number of children in need of services and the resultant scheduling and staffing needs for both the center and home program components, the number of children in need of intensive therapies, transportation, and funding.

Center-based programs are those wherein the children, with or without a parent or other family member, receive their primary educational and related service programs at a designated center for a specified amount of time per week. Child transportation, efficient utilization of staff time, willingness and comfort of family members to participate, and availability of resources are among the many considerations which may either discourage or encourage the use of the center-based program setting.

Regardless of the setting selected for delivery of services, several issues should be attended to:

1. Staffing requirements will be diverse and may include, but not be limited to: program coordinator, parent-infant educators, occupational therapist, physical therapist, speech pathologist, psychologist, social worker, nurse, and consultants (such as carpenter) as needed.

2. A transdisciplinary approach (see Chapter Three) should be encouraged to optimize service delivery.

3. Caseload and child/staff ratio must be sufficient to meet the needs of the children, be realistic in terms of time commitment of staff, and be efficient in terms of utilization of program resources. A low child/staff ratio is critical with handicapped children between birth and three years of age. Although formal standards have not been established, it appears that one staff member to three infants is a reasonable ratio. The caseload is even more difficult to ascertain. To illustrate, if the program is combined home and center-based, and one parent-infant educator serves each child in the center and in the home, his/her caseload would probably need to be smaller than if one parent-infant educator worked at the center and another parent-infant educator provided the services in the home.

4. Flexibility in scheduling needs consideration since parent/family involvement is so important. Working fathers and mothers may not be available during traditional 8:00 to 4:00 hours, and plans to accommodate their needs should be dealt with as well as possible.

5. Services provided in the home should be as carefully planned as those provided at the center. Specific lesson plans based on individual child goals, appropriate materials, pre and post-testing, demonstration of activities, and directions for recording data should be as much a part of the work with parents/families at home as they are at the center. It is important that the responsibilities of each participant, including the parent, be delineated and adhered to.

6. Ongoing monitoring and evaluation of the program's effectiveness is vital. The results of evaluation may help improve the program or suggest the need for changes in the selected style of delivery of services.

Reassessment

Formal reassessment, or re-evaluation, of a child should occur frequently, but at least annually. When the child is approximately two or two years, six months of age, communication with the local education agency should be initiated (if it is not already in place) to determine the nature and extent of re-evaluation that will be required in order to plan an appropriate program to begin at three years of age. Currently, the local education agency assumes responsibility for the handicapped child's education at age three. Reassessment at this time is more likely to ensure continuity of service and provides the local education agency with adequate time to prepare for the child's future educational placement.

Parent Involvement

Parent involvement in an infant program is essential. Often, a program will reflect as much time spent with the parents/families as with the child. The program will need to be flexible and should reflect alternative approaches as each family may have different types of needs. It is also important to consider different types of family structures, such as the single parent, foster parent, extended family. An active parent program provides emotional support to parents/families of the handicapped infant and toddler. Optimal programming would include contact with the parents as soon as concerns regarding the infant are raised, and would continue periodically and as frequently as is determined necessary.

The issues discussed in Chapter Three about parent programs are applicable to parents of handicapped infants. Current literature can provide provocative discussions about homogenous and heterogenous groups. Whichever model is chosen, parents should be sought to plan the design, purpose, and content of the parent program. The importance of parents' active involvement cannot be overemphasized.

EVALUATION

The need for evaluation in infant programming is viewed as assessing the initiation, development, and ongoing service provided in each facet of the program. Each program must evaluate the progress of the child, the total process of the delivery system, and the impact of services to families. Results of evaluation activities must feed back into the system in order to revise the system towards high relevancy.

RECOMMENDATIONS

1. Services for birth-to-three-year-olds, once initiated, should be comprehensive and systematic.

2. A transdisciplinary team should be responsible for birth-to-three program with a parent-infant educator as the team coordinator.

3. Interagency service/contract agreements should be worked out in the best interests of the birth-to-three handicapped child.

4. Parents should be involved in every aspect of service delivery.

5. All children should be reassessed at two years, six months of age, before entering a school district program for children ages three-to-five.

6. Within any birth-to-three program, an attempt shall be made to meet the emotional, community, and legal needs of parents as well as the educational and related service needs of the child.

APPENDICES

APPENDIX A
EVALUATION OF EARLY CHILDHOOD EDUCATION PROGRAMS

The purpose of evaluation is to provide information that will contribute to better decision making either for program improvement or program accountability. This essentially means that evaluation is not conducted for its own sake but in order to assist educators who have to make decisions about educational programs. Should this early childhood program be continued as is or be modified; does this identification process work properly; are parents informed about their rights under current federal and state legislation? These are all examples of important questions which need to be answered in the management of an early childhood education program. The function of evaluation is to assist in clarifying these questions and then to gather and analyze data that will help provide answers.

Evaluation is a rational, systematic process that can usually be carried out by the same people who are implementing the program. It involves description as well as judgement so it is not always numerically oriented. The five basic steps in the evaluation process can be briefly summarized as follows:

1. Plan the evaluation design. Identify the evaluation questions to be addressed or the objectives to be measured; specify the procedures for answering these questions; specify when to collect the data and how it will be analyzed.

2. Select or develop instrumentation.

3. Administer instrumentation or gather information.

4. Compile and analyze data or information.

5. Prepare a report or set of recommendations based on the results; i.e., put the results in a format that enables them to be useful in answering the questions for which they were gathered.

With this general overview of evaluation in mind, it is the intent of this section to set forth a sample evaluation design for an early childhood education program. This design will correspond to the various sections of this manual and should serve as a starting point in highlighting some of the important issues that evaluation can serve to examine. In most cases, specific instruments or devices have not been identified. Since much work needs to be done in this area, it will be incumbent upon the reader to develop or secure instruments for these purposes. Also, please feel free to modify any of the questions, procedures, or timelines to meet local needs and priorities. For evaluation to be helpful it must also be flexible and responsive.

CHILD-FIND

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
1. Have procedures been implemented to inform the community about the following: a. importance of early intervention b. availability of programs c. parent/child rights d. early warning signs	Documentation of newspaper articles, film clips, T.V., and radio advertisements, meetings, brochures and their distribution, etc.	This documentation should be collected on an ongoing basis and summarized in a descriptive manner on an annual basis.
2. Is there evidence that the community at large is aware of a., b., c., and d. above?	Conduct a telephone survey on a random sample of names in a phone book; get a political organization to gather such data when canvassing neighborhoods; or mail questionnaires to a random sample of voters.	This information should be collected every two or three years. You will want to tally the percentages of respondents who answer each question correctly and incorrectly. You may even want to do a breakdown by geographic area to see if there are regions missing in your coverage.
3. Is there evidence that community awareness is increasing?	Same procedures as above.	Use a pre-test/post-test design. Compare percentages before and after intervention and note increases or decreases.
4. Have procedures for locating all preschool children been implemented?	Documentation of such procedures, i.e., preschool round-up, etc. List of names of all preschool children and addresses.	This documentation should be collected at the conclusion of such activities, probably spring or summer, and should be summarized in a descriptive manner on an annual basis.

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
5. How effective are the location procedures?	Comparison of number of children located with hospital birth-rates for preceding years (taking into account mobility factors); comparison of number of children located with further kindergarten registration.	Same as #4. You may want to do a further analysis of this by geographical region to see if there are areas which are being overlooked.
6. Have the different sources for identification (i.e., community agencies, parents, doctors) been made aware of their role in this activity?	Documentation of procedures used to inform these sources of their role, i.e., brochures, meetings, phone calls, etc.	This documentation should be collected on an ongoing basis and summarized in a descriptive manner on an annual basis.
7. Is the identification/referral process effective?	Comparison of number of children referred with number diagnosed as handicapped.	This documentation should be collected on an ongoing basis and percentages should be computed on an annual basis.
	Comparison of number of children with incidence rates for community served.	
8. Have procedures for screening preschool children been implemented?	Documentation of procedures, lists of children screened, date and nature of screening, results of screening.	This documentation should be collected at the conclusion of the screening activity and should be summarized in a descriptive manner on an annual basis.

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
9. How effective are the screening procedures?	Comparison of number of children screened with number located. Are these equal? Comparison of number of children requiring diagnostic work with number screened. Does this figure exceed incidence rates for this community? Comparison of scores of children screened with normal distribution for selected standardized instrument.	Compute percentages for these comparisons at the conclusion of the screening activity.
10. Have procedures for conducting case-study evaluations been implemented?	Documentation of procedures, numbers of children evaluated, types of instruments, dates, etc.	This documentation should be collected on an ongoing basis and should be summarized in a descriptive manner on an annual basis.
11. How effective are the procedures for conducting case-study evaluations?	Interview or questionnaire distributed to participants of staffing (random sample) to see if data is helpful. Comparison of recommendations of case study with recommendations of staffing. Is there a great deal of consistency?	This documentation should be collected at least once a year and summarized in a descriptive manner.
12. Have procedures for conducting multi-disciplinary staffings been implemented?	Documentation of procedures, how many, who is involved, amount of time spent, records, etc.	This documentation should be collected on an ongoing basis and summarized in a descriptive manner on an annual basis.

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
13. How effective are the procedures for multi-disciplinary staffings?	Interview or questionnaire distributed to participants of staffings. Tally of number of appeals. Follow-up study with teaching staff to see if proposed placement was appropriate.	This documentation should be collected at least once a year and summarized in a descriptive manner on an annual basis.
14. Is an IEP developed for each child requiring special education services?	Documentation of IEP for each child.	This documentation should be collected on an ongoing basis and summarized in a descriptive manner on an annual basis.

SERVICE DELIVERY

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
1. Have procedures for ordering and utilizing equipment and materials been implemented?	Documentation of procedures, forms, inventories, frequency of use.	This documentation should be collected on an ongoing basis and summarized in a descriptive fashion on an annual basis.
2. Do these procedures require justification that materials and equipment are developmentally appropriate and geared to the handicapping conditions of the child?	Include a "rationale" section on ordering request. Follow-up observation by teacher to validate information.	This documentation should be collected on an ongoing basis. Results of follow-up should be fed back into system to correct errors in judgement.
3. How efficient are the procedures for ordering and utilizing equipment and materials?	Frequency of use of equipment survey of staff through interviews or questionnaires.	This documentation should be collected periodically, perhaps every 2 or 3 years. Results should be used to modify system.
4. Has a full continuum of services been implemented in the program?	Documentation of range of options available, numbers of children participating in each option, staff allocations.	This documentation should be compiled annually and summarized in a descriptive fashion.
5. Is there evidence that the learning environment (setting, facilities, climate) is adequate or can it be improved?	Survey of staff and parents through interviews or questionnaires, or on-site review by outside panel of experts.	This documentation should be collected annually or every 2 years. Numerical or descriptive data would suffice depending on instruments.

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
6. Have procedures for providing integration with non-handicapped children been implemented?	Documentation of procedures, number of handicapped and non-handicapped children participating, length or frequency of contact, nature of interaction.	This documentation should be collected annually and compiled in a descriptive fashion.
7. Have procedures for establishing parent involvement been implemented? Do these procedures accommodate the following range of services: a. parent awareness and education b. parent involvement in decision making, program planning and operation c. in-classroom participation d. parent-to-parent support groups	Documentation of range of services, numbers of parents involved in each, etc.	This documentation should be collected annually and compiled in a descriptive fashion.
8. How effective is the parent involvement component of the program?	Increase in numbers of parents involved or participating. Attitudes of parents about this component measured through interviews, questionnaires, or parental satisfaction ratings.	This documentation should be collected annually. Numbers and percentages of parents responding favorably and unfavorably should be compiled.
9. Is there evidence that the content of the curriculum is developmentally relevant?	Documentation that curriculum is sequential and based on learning theory. Hierarchy and/or taxonomy of skills to be learned during course of instruction.	This documentation should be delineated at the beginning of the program and periodically revised if necessary.

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
10. Is there evidence that the instructional strategy and curriculum are resulting in the attainment of the desired skill?	Test or performance of child on objective referenced instrument (standardized or teacher developed).	This documentation should be collected at the conclusion of each unit of instruction and summarized on the child's IEP.
11. Is there evidence that groupings are based on educational needs rather than common disabilities?	Documentation of procedures for determining groupings; policy statement.	This documentation should be delineated during the first year of the program and periodically revised if necessary.
12. Is there evidence that the staff utilization model is trans-disciplinary?	Job descriptions, staff assignment sheets, time-activity records, staff logs.	This documentation should be delineated during the first year of the project and periodically revised or reexamined if necessary.
13. Have procedures for the smooth transitioning of children into kindergarten and primary grades been put into place?	Documentation of procedures, forms, flow-charts, meetings, etc.	This documentation should be collected at least every two or three years and summarized in a descriptive fashion.
14. Are these transitioning procedures effective?	Attitude of staff (kingergarten, pre-kindergarten, and primary) regarding procedures. Follow-up of child progress via IEP.	Tally or describe staff response summarizing progress rates for sample of children. This documentation should occur every two or three years.

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
15. Is there evidence that the staff/child ratio is optimal or does it require modification?	Time/work sheets; survey of staff through interviews or questionnaires.	This documentation should be collected periodically, perhaps every two or three years.
16. Does the staff exhibit the full complement of skills necessary to accommodate all the demands of an early childhood program?	Staff evaluation through observation or output.	This documentation should be collected annually and should be used both for personnel decisions as well as in the needs assessment for staff development.
17. Do teachers, administrators, support personnel and parents have a positive attitude about the program?	Survey of these groups either through interviews or questionnaires.	This documentation should be collected every two or three years. Percentages of groups responding positively or negatively should be computed.
18. Is there evidence that the overall program is making a significant difference in the achievement (learning) of children?	Group progress on standardized instruments, either norm-referenced or criterion referenced. Group tally of numbers of objectives mastered.	This documentation should be collected annually using a pre-test/post-test design if possible.

STAFF DEVELOPMENT

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
1. Has a needs assessment been implemented to determine priorities for staff development?	Documentation of needs assessment procedures, who was surveyed, when, how, with what results?	This documentation should be provided at the conclusion of needs assessment activity and should occur every two or three years.
2. Have systematic procedures for inservice training been implemented?	Documentation of procedures, i.e., identification of objectives, specification of format, dates, attendance, etc.	This documentation should be collected on an ongoing basis and summarized in a descriptive manner annually.
3. How effective are the procedures for inservice training?	Attitude questionnaire on content, facilities, organization, etc., given to client group.	Tally of results at conclusion of inservice. Should occur after each inservice.
4. Have the client groups acquired the awareness, knowledge or proficiency which was the focus of the training?	Cognitive test, or onsite observation of skills, or development of a product.	Tally or results at conclusion of measurement. Should occur after each inservice. If possible pre-test/post-test designs should be used.

BIRTH-TO-THREE SERVICES

EVALUATION QUESTIONS	PROCEDURES	WHEN AND HOW
For this section you will want to pull many of the same questions that were delineated in the Child-Find and Service Delivery sections. In addition, you may want to add the following:		
1. Has a system for coordinating contacts between the various public and private agencies been implemented?	Documentation of numbers of contracts, description of coordinating system, flow-charts, graphs, etc.	This documentation should be delineated at the beginning of the program and periodically revised if necessary.
2. Have procedures for smooth transitioning of children into pre-school programs been put into place?	Documentation of procedures, forms, flow-charts, meetings, etc.	This documentation should be collected at least every two or three years and summarized in a descriptive fashion.
3. Has a support system been established for families which can assist the child/family during the first six months of life?	Documentation of procedures, number of contacts, etc.	This documentation should be collected every two or three months during the beginning of the program.

APPENDIX B

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